

NONPROFIT HEALTH SERVICE PLANS – LARGE GROUP COVERAGE

COMPANY:	NAIC Code:
FORM(S):	
DATE:	
SERFF TRACKING NO.:	

The items listed below may paraphrase the law or regulation. **The checklist is not required to be included with a form filing.** It should be used as a guide in determining which laws and regulations apply to the contract. Unless otherwise specified, all section references are to the Insurance Article of the Annotated Code of Maryland.

Brief Description & Law/Regulation Cite**"X" Means
Applicable****Form/ Page****A. Filing Submission Requirements**

A1.	NAIC Company Number on Submission Letter – COMAR 31.04.17.03B		
A2.	Listing of Forms – COMAR 31.04.17.03C(4)		
A3.	Description of Unique Features – COMAR 31.04.17.03J		
A4.	Contracts with Insert Pages – COMAR 31.04.17.04B		
a.	Form Number – COMAR 31.04.17.04B(1)(a)		
b.	Description of How Pages will be Combined – COMAR 31.04.17.04B(1)(b)(i)		
c.	Listing of Substitute Pages – COMAR 31.04.17.04B(1)(b)(ii)		
d.	Form Number and Approval Date for Pages Replaced – COMAR 31.04.17.04B(3)(a)		
e.	Copy of Currently Approved Contract – COMAR 31.04.17.04B(3)(b)		
A5.	Contracts Comprised of Sections – COMAR 31.04.17.04C		
a.	Form Number – COMAR 31.04.17.04C(1)(a)		
b.	Description of How Sections will be Combined – COMAR 31.04.17.04C(1)(b)(i)		
c.	Listing of Substitute Sections – COMAR 31.04.17.04.C(1)(b)(ii)		

d. Form Number and Approval Date for Sections Replaced – COMAR 31.04.17.04C(3)(a)		
e. Copy of Currently Approved Contract – COMAR 31.04.17.04C(3)(b)		
A6. Premium Rates – COMAR 31.10.01.03A <ul style="list-style-type: none"> Required to be Filed in Same SERFF Tracking # as Forms 		
A7. Filing Fees Paid – §2-112		
A8. Readability Certification – COMAR 31.10.02		
A9. Provide written assurance that contract will not be issued to employers with less than 50 eligible employees - Title 15, Subtitle 12		
A10. Transmittal Form – COMAR 31.04.17.03C(1) <i>Required for paper filings only</i>		
A11. Self-addressed Stamped Envelope – COMAR 31.04.17.03C(3) <i>Required for paper filings only</i>		
A12. Duplicate Forms – COMAR 31.04.17.03A <i>Required for paper filings only</i>		

B. General Requirements for Forms

B1. Size of Type – COMAR 31.10.02.02A(4)		
B2. Unacceptable Modifications – COMAR 31.04.17.03H		
B3. Specimen Data – COMAR 31.04.17.03K		
B4. Form Number – COMAR 31.04.17.03D <ul style="list-style-type: none"> For each Form Schedule Item submitted in SERFF, number printed in lower lefthand corner of first page of form must match number entered in "Form Number" field 		
B5. Corporate Name and Address – COMAR 31.04.17.03G		
B6. Signature of Officer – COMAR 31.04.17.03M		
B7. Signature of Policyholder for Reduction Rider – COMAR 31.10.01.03E		
B8. Disclosure of Not-for-profit Status – §14-103		

B10.	Form contains items in brackets, denoting variability. Submit specific description of how each item can vary. If other text is desired, include specific text – COMAR 31.04.17.04A(2)		
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C. Eligibility, Enrollment, and Termination of Coverage

C1.	Guaranteed Availability of Coverage – 42 USC § 300gg-1, 45 CFR §147.104(a), §15-1410 <ul style="list-style-type: none"> Carrier must offer to any large employer in the state all large group products that are approved for sale, and must accept any employer that applies for any of those products 		
C2.	May not impose a waiting period that exceeds 90 days – 42 USC § 300gg-7, 45 CFR §147.116, §15-137.1		
C3.	May Not Establish Eligibility Rules Based on Health Status – §15-1406(a)		
C4.	Deferred Effective Date Provisions Prohibited – 45 CFR §146.121(e)		
C5.	Domestic Partner Coverage, including Child Dependents of Domestic Partner – §15-403.2, COMAR 31.10.35		
C6.	Newborn/Adopted Children/Grandchildren/Children under Guardianship – §§15-401, 15-403, 15-403.1		
C7.	Child Dependent Coverage to Age 26 – 42 USC § 300gg-14, 45 CFR §147.120, MIA Bulletin 10-17, §15-137.1		
C8.	Coverage of Grandchildren and Individuals Under Guardianship to Age 25 – §15-418		
C9.	Part-Time Students with Disabilities – §15-417		
C10.	Incapacitated Children – §15-402		
C11.	Court Ordered Coverage of Children – §15-405		
a.	Coverage Requirements for Enrollment of Child – §15-405(c)		
b.	Special Enrollment Period for Employee and Child Required – §15-405(h)		
c.	Special Enrollment Period for Child Required – §15-405(i)		
d.	Prohibited Denials of Coverage for Child Enrollment – §15-405(d)		

C12. Open Enrollment		
a. Spouse Loses Job – §15-411		
b. Dependent Children Upon Death of Spouse – §15-404		
C13. Special Enrollment Period Provisions		
a. For employee/dependent who loses other coverage – §15-1406(d)		
b. For individuals who become dependents of employee – §15-1406.1(c)(1)		
c. Permit employee to enroll himself when he or she acquires new dependents and enrolls such dependents – §15-1406.1(c)(2)		
d. For spouse of employee at birth or adoption of a child – §15-1406.1(c)(3)		
C14. Permissible Causes of Termination – §15-1408		
C15. May only rescind contract for fraud or intentional misrepresentation and must provide 30-day advance notice – 42 USC § 300gg-12, 45 CFR §147.128, MIA Bulletin 10-23, §15-137.1		
C16. Extension of Benefits – §15-833		
C17. Continuation of Coverage		
a. Termination of Employment – §15-409; COMAR 31.11.04		
b. Divorced Spouses – §15-408; COMAR 31.11.02		
c. Surviving Spouses – §15-407; COMAR 31.11.03		

D. Mandated Benefits

D1. Emergency Services – 42 USC § 300gg-19a, 45 CFR §147.138(b), MIA Bulletin 10-23, §15-137.1 <ul style="list-style-type: none"> • “Emergency services” definition • “Emergency medical condition” definition • No prior authorization • No limitations or exclusions for non-network providers • No administrative requirements on non-network emergency services that are not imposed in-network • Amount of reimbursement for non-network providers 		
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D2.	Preventive Services		
a.	In-network preventive services as defined by the ACA, including women's preventive services in accordance with HRSA guidelines, required to be covered without cost-sharing – 45 CFR §147.130, MIA Bulletin 10-23, §15-137.1		
b.	Covered annual preventive visits/screenings must be provided once at any time during the contract year – §15-135		
D3.	Child Wellness (May not be subject to deductible) – §15-817 <ul style="list-style-type: none"> Amended to include all visits for obesity evaluation and management – §15-817(c)(2)(v); House Bill 1017, Chpt. 596, Acts of 2010, effective 10/1/10 Amended to include all visits for and costs of developmental screening as recommended by the American Academy of Pediatrics – §15-817(c)(2)(vi); House Bill 1017, Chpt. 596, Acts of 2010, effective 10/1/10 Expanded coverage for laboratory tests considered necessary by physician for services in §15-817 – §15-817(c)(2)(vii); House Bill 1017, Chpt. 596, Acts of 2010, effective 10/1/10 		
D4.	Breast Cancer Screening in accordance with latest screening guidelines issued by American Cancer Society (may not be subject to deductible) – §15-814		
D5.	Colorectal Cancer Screening – §15-837		
D6.	Prostate Cancer Screening – §15-825		
D7.	Annual Chlamydia Screening Test – §15-829		
D8.	Human Papillomavirus Screening Test – §15-829		
D9.	Osteoporosis Prevention – §15-823		
D10.	Mental Illness and Substance Abuse – §15-802		
a.	Required benefits for inpatient care, partial hospitalization, and outpatient care (including all office visits and psychological and neuropsychological testing for diagnostic purposes) – §15-802(c)		
b.	Required benefits for residential crisis services – §15-840, Insurance		
c.	Methadone Maintenance Copayments – §15-802(d)(5)		

d. May not apply any financial requirement or quantitative treatment limitation in any benefit classification that is more restrictive than the predominant financial requirement/treatment limitation of that type that applies to substantially all medical/surgical benefits in the same classification – §15-802(d)(2)(ii), 45 CFR §146.136(c)(2)(i)		
e. For purposes of determining mental health parity, benefit classifications limited to inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs – §15-802(d)(2)(ii), 45 CFR §146.136(c)(2)(ii)		
f. Exceptions to six benefit classifications provided only for multi-tiered prescription drug benefits, multiple network tiers, and outpatient sub-classification of office visits, separate from other outpatient items and services – §15-802(d)(2)(ii), 45 CFR §146.136(c)(3)(iii)		
g. 60 day limit for partial hospitalization described in §15-802(d)(2)(iv) only permitted upon demonstration of compliance with 45 CFR §146.136(c)(2)(i)		
h. Prohibition on nonquantitative treatment limitations (including UR requirements) that are more restrictive than requirements for physical illnesses – §15-802(d)(2)-(4), 45 CFR §146.136(c)(4)		
D11. Maternity Care – §§ 15-811, 15-812		
a. Required benefits for inpatient hospitalization and home visits for mothers and newborns – §15-812		
b. Coverage of home visits for newborns may not be subject to deductibles, copays or coinsurance – §15-812(g)		
c. For High Deductible Health Plans, home visits may not be subject to copays or coinsurance, but may be subject to deductible – §15-812(g)(2)		
d. Additional 4 days inpatient stay for newborn If mother requires inpatient care – §15-811		
e. Hospitalization Same as Sickness – §15-811		
f. Maternity Benefits Provided Regardless of Marital Status – §15-506		
D12. In Vitro Fertilization – §15-810 <ul style="list-style-type: none"> Expanded to include coverage for married same-sex couples – House Bill 838, Chpt. 483, Acts of 2015, effective 7/1/15 		

D13.	Home Health Care – §15-808		
D14.	Coverage for Home Visits for Surgical Removal of Testicle If Less than 48 Hours of Inpatient Hospitalization is Provided or Surgery Performed on an Outpatient Basis – §15-832		
D15.	Coverage for Inpatient Hospitalization for a Minimum of 48 Hours Following Mastectomy and Coverage for Home Visits – §15-832.1		
D16.	Reconstructive Breast Surgery – §15-815 <ul style="list-style-type: none"> Amended definition of mastectomy Amended to include coverage for physical complications of all stages of mastectomy, including lymphedemas, in manner determined by physician – Senate Bill 57, Chpt. 17, Acts of 2010, effective 4/13/10 		
D17.	Breast Prosthesis – §15-834		
D18.	Hair Protheses for Hair Loss Resulting from Chemotherapy or Radiation Treatment for Cancer – §15-836		
D19.	Prosthetic Devices (including Components and Repairs) – §15-844		
D20.	Orthopedic Braces – §15-820		
D21.	Hearing Aids - Coverage for Children – §15-838		
	<ul style="list-style-type: none"> The \$1400 limit may not be applied – 45 CFR §147.126 (Benefits for hearing aids for children are considered essential health benefits in large group contracts because the Maryland-selected benchmark plan includes these benefits. See FAQ 10 from the February 17, 2012 CMS Plan Management FAQ <i>Frequently Asked Questions on the Essential Health Benefits Bulletin</i>) 		
	<ul style="list-style-type: none"> Coverage for adults: If hearing aid coverage is provided with a dollar limit, must allow the choice of a higher price hearing aid with difference in cost paid by the covered person – §15-838(d) 		
D22.	Diabetes Equipment, Supplies, Training – §15-822		
D23.	Ostomy Equipment and Supplies – §15-848, Senate Bill 241, Chapter 23, Acts of 2015, effective 10/1/15		
D24.	Medical Food and Low Protein Food – §15-807		
D25.	Amino Acid-Based Elemental Formula – §15-843		

D26. Blood Products – §15-803		
D27. General Anesthesia for Dental Care – §15-828		
D28. Treatment of Morbid Obesity – §15-839		
<ul style="list-style-type: none"> If utilization review criteria are included, criteria must comply with COMAR 31.10.33 		
D29. Coverage for Medical Clinical Trials – §15-827 <ul style="list-style-type: none"> Expanded definition of approved clinical trial - 42 USC § 300gg-8(d), §15-137.1 		
D30. Health Care Cost Containment		
a. Outpatient Benefit – §15-819(b)(1)		
b. Second Opinion – §15-819(b)(2)		
D31. Coverage of Face, Neck or Head (TMJ Syndrome) – §15-821		
D32. Cleft Lip/Cleft Palate – §15-818		
D33. Habilitative Services for Children – §15-835 (amended definition, effective 7/1/12, House Bill 1055, Chpt. 294, Acts of 2012)		
<ul style="list-style-type: none"> If utilization review criteria for treatment of autism and autism spectrum disorders are included, criteria must comply with COMAR 31.10.39. 		
<ul style="list-style-type: none"> Habilitative services benefit may not exclude applied behavior analysis for the treatment of autism and autism spectrum disorders – COMAR 31.10.39.03B and G 		
D34. Telemedicine Services – §15-139		
D35. Hospice (Required Offering)– §15-809; COMAR 31.10.09		
D36. Alzheimer's Disease (Required Offering) – §15-801; COMAR 31.11.05		

E. Prescription Drug Benefits (*applicable only if plan includes coverage for prescription drugs*)

E1. Coverage for Contraceptive Drugs or Devices – §15-826		
E2. Coverage for Smoking Cessation Treatment – §15-841		
E3. Coverage for Certain Prescription Eye Drop Refills – §15-845		

E4.	90 Day Supply for Maintenance Drugs – §15-824		
E5.	Choice of Pharmacy for Filling Prescriptions – §15-806		
E6.	For Formulary Benefits – Right to Receive Non-Formulary Drugs – §15-831		
E7.	Off Label Use of Drugs – §15-804		
E8.	Step Therapy or Fail-First Protocols Prohibited under Certain Circumstances – §15-142		
E9.	Copayment May Not Exceed Retail Price of Drug – §15-842		
E10.	Coverage of Drugs From Local Pharmacies Same as Mail Order – §15-805		
E11.	Chemotherapy Parity – Coverage for benefits at same (or better) level for oral chemotherapy as benefits for cancer chemotherapy that is administered intravenously or by injection – §15-846		
E12.	Specialty Drugs – Copayment/Coinsurance Limits – §15-847, effective 10/1/14 (applicability effective 1/1/16)		
E13.	Abuse-Deterrent Opioid Analgesic Drug Products – Tier Placement and Step Therapy – §15-849, Senate Bill 606, Chpt. 372, Acts of 2015, effective 1/1/16		

F. Preferred Provider Benefits

F1.	Requirements for Physician Rating Systems – Title 15, Subtitle 17		
a)	Must provide documentation that physician rating system has been approved by ratings examiner – §15-1702(a)		
b)	Must provide certification that HMO has established: <ul style="list-style-type: none"> • Appeals process for physicians – §15-1703(a)(1) • System to notify physicians of changes to ratings – §15-1703(a)(2) • Process to post required information on HMO's website – §15-1703(c) 		
c)	Must file annual report with Commissioner – §15-1704		

F2.	<p>Right to Request Referral to Specialist Not on Carrier's Provider Panel – §15-830(d)</p> <ul style="list-style-type: none"> Referral must be granted if the carrier cannot provide reasonable access to a specialist without unreasonable travel or delay Deleted the provision that the out-of-network provider must agree to accept the same reimbursement as a network specialist Amended to include nonphysician specialist 		
F3.	<p>Gatekeeper-Type PPO</p> <p>a. Right to Receive Care From In-Network OB/GYN Without Prior Visit to Primary Care Provider – §15-816</p>		
	<ul style="list-style-type: none"> Amended to require right to receive routine OB/GYN care from In-Network, Certified Nurse Midwife without prior visit to PCP – §15-816(d) 		
	<ul style="list-style-type: none"> No prior visit to PCP for all care received from OB/GYN, including non-routine care and the ordering of related obstetrical and gynecological items and services – 42 USC § 300gg-19a, 45 CFR §147.138(a), MIA Bulletin 10-23, §15-137.1 		
	<p>b. Right to Standing Referral to Network Specialist – §15-830(b)</p>		
	<ul style="list-style-type: none"> Amended to require a standing referral to obstetrician for pregnant members through the postpartum period. Written treatment plan may not be required – §15-830(c) 		
	<p>c. Right to Choose Any Provider in Network as PCP and for Children, Right to Select Allopathic or Osteopathic Pediatrician in Network – 42 USC § 300gg-19a, 45 CFR §147.138(a), MIA Bulletin 10-23, §15-137.1</p>		
F4.	<p>When member transitions from another carrier or managed care organization, receiving carrier must allow member to continue to receive health care services from a nonparticipating provider under certain circumstances – §15-140(d)</p>		
F5.	<p>Coinsurance Amounts for Preferred Provider Must Be Based on Negotiated Fees With Insurer – §15-118(c)</p>		
F6.	<p>Coinsurance Differential – Difference between coinsurance percentage for non-preferred and preferred providers may not exceed 20 percentage points – §14-205(b)(2); Senate Bill 314, Chpt. 537, Acts of 2010, effective 10/1/10 (applicability effective 7/1/11)</p>		

F7.	Allowed Amounts – The allowed amount paid to non-preferred providers for a health care service covered under a PPO contract may not be less than the allowed amount paid to a similarly licensed provider who is a preferred provider for the same service in the same region – §14-205(b)(4), Senate Bill 314, Chpt. 537, Acts of 2010, effective 10/1/10 (applicability effective 7/1/11)		
F8.	Balance Billing – Any contract provisions requiring the insured to pay the balance bill may not apply to an on-call or hospital-based physician who has accepted an assignment of benefits in accordance with §14-205.2 – §14-205(b)(3), Senate Bill 314, Chpt. 537, Acts of 2010, effective 10/1/10 (applicability effective 7/1/11)		
F9.	Assignment of Benefits for On-Call and Hospital-Based Physicians Payment Rules – §14-205.2		
F10.	Assignment of Benefits for Physicians other than On-Call and Hospital Based Physicians Payment Rules – §14-205.3		
F11.	Identify office and process for filing complaints – §15-112(j)		

G. Practitioners

G1.	Certified Nurse Practitioner, Nurse Anesthetist; Nurse Midwife – §§15-703, 15-708, 15-709		
G2.	Health Care Providers – §15-701		
G3.	Social Workers – §15-707		
G4.	Podiatrists – §15-713		
G5.	Community Health Resource – §15-715		

H. Required Standard Provisions

H1.	Entire Contract; Changes – COMAR 31.11.10.04A		
H2.	Contestability of the Contract – COMAR 31.11.10.04B		
H3.	Notice of Claim – COMAR 31.11.10.04C		
H4.	Claim Forms – COMAR 31.11.10.04D		
H5.	Proofs of Loss – COMAR 31.11.10.04E		

	<ul style="list-style-type: none"> Methods for Claim Submission – §15-1011, Senate Bill 450, Chpt. 35, Acts of 2015, effective 10/1/15 (applicability effective 10/1/17) 		
	<ul style="list-style-type: none"> Provider must be permitted minimum of 180 days to file claim – §15-1005(d) 		
H6.	Time Payment of Claims – COMAR 31.11.10.04F		
H7.	Payment of Claims – COMAR 31.11.10.04G		
H8.	Legal Action – COMAR 31.11.10.04H		
H9.	Grace Period – COMAR 31.11.10.04I		
H10.	Certificates – COMAR 31.11.10.04J		
H11.	Addition of Employees/Members – COMAR 31.11.10.04K		
H12.	Misstatement of Age – COMAR 31.11.10.04L		
H13.	Group Contract Holder Liable for Premium Until Notice of Termination is Received – COMAR 31.11.10.04M		
H14.	Premium Due Date – COMAR 31.11.10.04N		

I. Optional Provisions

I1.	Physical Examination – COMAR 31.11.10.07A		
I2.	Autopsy – COMAR 31.11.10.07B		
I3.	Arbitration – COMAR 31.11.10.07C		

J. Prohibited Provisions, Limitations, and Exclusions

J1.	Premium - May Not Charge Extra Premium Based on Health Status – §15-1407		
J2.	Annual dollar limits for essential health benefits are prohibited – 42 USC § 300gg-11, 45 CFR §147.126, MIA Bulletin 10-23, §15-137.1		
J3.	Lifetime dollar limits for essential health benefits are prohibited – 42 USC § 300gg-11, 45 CFR §147.126, MIA Bulletin 10-23, §15-137.1		

J4.	Benefits for Treatment of a Specified Disease or Diagnosis May Not be Subject to Different Copays, Coinsurance, Deductibles, Annual or Lifetime Maximums – §27-913		
J5.	Benefits for infertility may not discriminate against married same-sex couples – 15-810(b), House Bill 838, Chpt. 483, Acts of 2015, effective 7/1/15		
J6.	May not exclude benefits for treatment received in State Hospitals, etc., Charitable or Otherwise – §15-602		
J7.	No Reduction for Medical Assistance Program – §15-502		
J8.	Denial of Reimbursement for Pre-authorized Care Prohibited Except for Limited Reasons – §15-1009		
J9.	May not coordinate against guaranteed renewable individual intensive care or specified disease policies – §15-104(c)		
J10.	May not provide benefits that are secondary to benefits payable under Personal Injury Protection (PIP) – §15-104(d)		
J11.	House Confinement, Medical Treatment Permitted Elsewhere – §15-505		
J12.	Frequency of Physician Visits – COMAR 31.10.01.03-I		
J13.	Physical Therapist Time Limitations – §15-711(b)		
J14.	May not include a limitation or exclusion for a pre-existing condition – 42 USC § 300gg-3, 45 CFR §147.108(b), MIA Bulletin 10-23, §15-137.1		
J15.	Prohibited Suicide or Self-Inflicted Injury Exclusion – 45 CFR §146.121(b)(2)(iii)		
J16.	Denial of Medically Necessary Inpatient Ancillary Charges Prohibited – §27-303, MIA Bulletin L&H 99-25		
J17.	May not limit or exclude loss due to member's commission of or attempt to commit a crime – COMAR 31.11.10.06A		
J18.	May not limit or exclude loss due to member being engaged in an illegal occupation – COMAR 31.11.10.06B		

J19.	May not limit or exclude loss: <ul style="list-style-type: none"> • Sustained or contracted in consequence of the member being intoxicated or under the influence of any drug – COMAR 31.11.10.06C(1)(a) • Due to the use of alcohol – COMAR 31.11.10.06C(1)(b) • Due to the use of drugs or narcotics – COMAR 31.11.10.06C(1)(c) • Due to alcoholism or drug addiction – COMAR 31.11.10.06C(1)(d) 		
J20.	Prohibited Exclusion for “Chronic or Organic Disease” – COMAR 31.10.01.03-O		
J21.	May not deny, cancel, or refuse to renew coverage due to Exposure to Diethylstilbestrol (DES) – §15-503		
J22.	May Not Discourage or Prohibit Access to the 911 Emergency System – §15-126		
J23.	May Not Condition Benefits on Payment by Claimant of Covered Expenses – COMAR 31.10.01.03P		
J24.	Good Health Warranty Prohibited – COMAR 31.04.17.10B		
J25.	“Strict Compliance” Language Prohibited – COMAR 31.10.01.03Q		
J26.	Advertising Prohibited – COMAR 31.04.17.07		

K. Other

K1.	Must be Given At Least 45 Day Notice of Premium Increase At Renewal – §15-122		
K2.	Requirements for Wellness Programs – 45 CFR §146.121(f), §§ 15-137.1, 15-509		
a.	Participatory Wellness Programs: <ul style="list-style-type: none"> • Program must be available to all similarly situated individuals - §15-509(c)(2) 		
b.	Health-Contingent Wellness Programs: <ol style="list-style-type: none"> 1. Full reward must be available to all similarly situated individuals - §15-509(d)(4) and (g)(1)(ii) 		
	<ol style="list-style-type: none"> 2. Must provide chance to qualify for reward at least once per year – §15-509(d)(1) and (g)(1)(i) 		

3. Combined reward for all health-contingent wellness programs may not exceed 30% of premium, increased additional 20 percentage points (to 50%) for tobacco cessation – §15-509(d)(2) and (g)(1)(i)		
4. Must allow reasonable alternative standard (or waiver of standard) for obtaining reward		
i) Activity-only Wellness Program: <ul style="list-style-type: none"> • Alternative standard required if unreasonably difficult to satisfy (or inadvisable to attempt to satisfy) standard due to medical condition – 45 CFR §146.121(f)(3)(iv)(A) • Carrier may require individual's physician to verify that alternative standard is needed due to medical condition – 45 CFR §146.121(f)(3)(iv)(E) • Alternative standard must accommodate recommendations of individual's physician – 45 CFR §146.121(f)(3)(iv)(C)(4) 		
ii) Outcome-based Wellness Program: <ul style="list-style-type: none"> • Alternative standard required if initial standard is not met for any reason – 45 CFR §146.121(f)(4)(iv)(A) • Carrier may <i>NOT</i> require individual's physician to verify that alternative standard is needed due to medical condition – 45 CFR §146.121(f)(4)(iv)(E) • Alternative standard must accommodate recommendations of individual's physician – 45 CFR §146.121(f)(4)(iv)(C)(4) 		
5. Certificate must disclose availability of reasonable alternative standard (including contact information for obtaining reasonable alternative standard) and that recommendations of individual's personal physician will be accommodated – 45 CFR §146.121(f)(3)(v) and (f)(4)(v)		
K3. Annual limitation on cost-sharing (including copays, coinsurance, and deductibles) for essential health benefits – 42 USC § 300gg-6, 45 CFR §156.130(a), §15-137.1		
a. For each plan year, cost sharing may not exceed the dollar limit for calendar year 2014, increased by the premium adjustment percentage (if any) applicable to the current plan year <ul style="list-style-type: none"> • For Plan Year 2015 – may not exceed \$6,600 for self-only coverage and \$13,200 for other than self-only coverage. • For Plan Year 2016 – may not exceed \$6,850 for self-only coverage and \$13,700 for other than self-only coverage. 		

b.	Out-of-network cost sharing is not required to count toward the limit – 45 CFR§ 156.130(c)		
c.	The annual limitation on cost sharing for self-only coverage applies to all individuals regardless of whether the individual is covered by a self-only plan or is covered by a plan that is other than self-only – 80 FR 10825		
K4.	Payment of Hospitals Based on Rate Set by Health Services Cost Review Commission – §15-604		
K5.	Reimbursement for Services Paid for or Provided by Department of Health and Mental Hygiene – §15-603		
K6.	Reimbursement to ambulance service providers – §15-138		
K7.	Payment of Claims – §15-1005		
K8.	Required statement of principal claims payment practices – §14-104		
a.	Surgical procedures performed by two or more surgeons – §14-104(b)(1)		
b.	Services provided in-area by nonparticipating providers – §14-104(b)(2)		
c.	Services provided out-of-area by affiliated plans and affiliated providers – §14-104(b)(3)		
K9.	Right to Elect Alternative Benefits – COMAR 31.10.01.03G		
K10.	Standard of Time – COMAR 31.10.01.03C		
K11.	Damage to Conveyance – COMAR 31.10.01.03N		
K12.	Required Exclusion for Prohibited Practitioner Referral – §15-110(d)		
K13.	Complaint process for coverage decisions – Title 15, Subtitle 10D		

L. Utilization Review

L1.	Grievance Procedure Not Included. Please Advise Where Grievance Information Is Provided – §15-10A-02(k)		
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L2.	Initial authorization of course of treatment made:		
a.	For non-emergencies, within 2 working days of receipt of information necessary to make determination – §15-10B-06(a)(1)(i)		
b.	For extended stays or additional health care services, within 1 working day of receipt of necessary information – §15-10B-06(a)(1)(ii)		
c.	For emergency inpatient or residential crisis services admissions for the treatment of a mental, emotional, or substance abuse disorder, within 2 hours of receipt of the necessary information – §15-10B-06(a)(3)		
L3.	PRA must inform health care provider that additional information is needed to make determination within 3 calendar days after initial request – §15-10B-06(a)(2)		
L4.	Notice of adverse decision must be provided within 5 days after adverse decision is made – §15-10A-02(f)(2)		
L5.	May not retroactively deny approval of preauthorized services – §15-10B-07(c)		
L6.	May not deny authorization for inpatient emergency care on basis of late notification from the hospital, if patient's condition prevented the hospital from knowing insurance status – §15-10B-06(c)		
L7.	Involuntary or voluntary psychiatric admission of patient in danger - may not issue adverse decision as to admission during first 24 hours after voluntary inpatient admission or 72 hours after involuntary admission – §15-10B-06(d)		
L8.	Emergency care – 42 USC § 300gg-19a, 45 CFR §147.138(b), MIA Bulletin 10-23, §15-137.1 <ul style="list-style-type: none"> • May not require preauthorization for emergency care • No administrative requirements on non-network emergency services that are not imposed in-network 		
L9.	When member transitions from another carrier or managed care organization, receiving carrier must, upon request, accept a preauthorization from the relinquishing carrier for the lesser of the course of treatment or 90 days; and for pregnancy the duration of the 3 trimesters of pregnancy and the initial postpartum visit – §15-140(c)		

M. Applications

M1.	Check-off boxes required for carrier name if application is to be used by more than one carrier – COMAR 31.04.17.06-I(2)		
M2.	Application must clearly identify coverages underwritten by each carrier, when more than one carrier uses the same application with the same group applicant – COMAR 31.04.17.06-I(3)		
M3.	Application shall stipulate the plan and amount of insurance and any added optional benefits applied for – COMAR 31.04.17.06A		
M4.	Waiting period may not exceed 90 days – 42 USC § 300gg-7, 45 CFR §147.116, §15-137.1		
M5.	May not reject entire group due to underwriting – 42 USC § 300gg-1, 45 CFR §147.104(a), §15-1410		
M6.	May not deny coverage to individual due to underwriting – §15-1406		
M7.	May Not Inquire About Genetic Tests or Genetic Information – §27-909		
M8.	Health questions (if included) must be asked to the best of the applicant's knowledge and belief, or application must include statement that all answers provided are representations and are not warranties – COMAR 31.04.17.06E		
M9.	Questions about "hazardous activities" must list activities considered to be "hazardous" – COMAR 31.04.17.06C		
M10.	Questions about the use of "habit-forming drugs" must list specific drugs considered to be "habit-forming" – COMAR 31.04.17.06D		
M11.	Questions about symptoms or indications of physical/mental conditions must ask about "known symptoms" and "known indications" – COMAR 31.04.17.06F and G		
M12.	If application is to be completed by more than one individual, application signature box must clearly indicate that signature applies only to portion of application completed by that individual – COMAR 31.04.17.06J		
M13.	Insurance Fraud-Required Disclosure Statement – §27-805 (amended effective 1/1/13, House Bill 301, Chpt. 120, Acts of 2012), MIA Bulletin 12-07		